Dunn Chiropractic
YOU. OPTIMIZED.

Welcome!

PERSONAL INFORMATION

PLEASE PRINT

First Name:_____**M.I**._____**Last Name**:_____**Preferred Name**:_____

Address:_____**City**:_____**State:**_____**Zip:**_____

Birthdate:_____/_____/_____ **Age**_____ **Gender**: □ Male □ Female □ Unspecified

Primary Phone:_____ **Cell Phone**:_____ **Work Phone**:_____

Home Email:_____ **Work Email**:_____

By providing my email address, I authorize my doctor to contact me via the email address(es) provided.

Which email would you like us to use to communicate with you? (check one) □ Home □ Work

Contact Method: (check one) □ Primary Phone □ Cell Phone □ Work Phone □ Home Email □ Work Email □ Text

Occupation: _____ **Employer:** _____

Status: (check one) □ Single □ Married □ Divorced □ Widowed □ Separated **Children?** □ Yes □ No How many? _____

Spouse's Name: _____

Race: □ White □ Black/African American □ Hispanic/Latino □ Asian □ Native American □ Other _____ □ I choose not to specify

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino □ Other_____ □ I choose not to specify

Emergency Contact: _____ **Relationship**: _____ **Phone:** _____

Family Physician Name: _____ City: _____

How were you referred to Dunn Chiropractic? □ Patient_____ □ Friend/Co-worker_____

□ Social media □ Internet □ Sign □ Physician □ Physical Therapist □ Acupuncturist □ Massage Therapist □ Dentist □ Other

REASON FOR VISIT

What brings you to our office today? □ I'm here for wellness care □ I'm dealing with some health challenges/complaints

If you are experiencing symptoms, what is your chief complaint today? _____

What do you think caused this complaint(s)? _____

_____

When did this complaint begin? _____/_____/_____

My complaint is: □ Constant □ Comes and goes

With time are your symptoms: □ Improving □ Getting worse □ Staying about the same

Have you had this or similar complaint in the past? □ No □ Yes If "Yes", when?_____

What does your complaint (s) feel like? Circle all that apply*: Sharp / Dull / Sore / Stiff / Tight / Aching / Spasms / Throbbing / Stabbing / Shooting / Burning / Cramping / Nagging / Tingling / Numbness / Other*_____

It interferes with: □ Work □ Sleep □ Walking □ Exercise □ Sitting □ Hobbies □ Mood □ Other _____

What have you done previously to get relief? _____

Other healthcare providers seen: □ MD/DO □ Chiropractor □ Physical Therapist □ Dentist □ Massage Therapist

Provider's Name: _____**Date Consulted:** _____

What have you been told is the problem/diagnosis? _____

What aggravates the complaint? Circle all that apply: Sitting / Standing / Walking / Getting up from seat / Walking stairs / Inactivity Sleeping / Physical Activity / Exercise / Movement / Bending Forward / Bending backward / Twisting / Reaching / Lifting / Desk work Sneezing / Coughing / Driving / Everything / Nothing / Unknown / Other: _____

Name:_____ Date: _____

What relieves the complaint? Circle all that apply: Sitting / Standing / Walking / Resting / Exercise / Movement / Stretching Massage / Chiropractic / Heat / Ice / Laying down / Medication / Nothing / Unknown / Other: _____

How often do you experience your symptoms? □ 25% of the day □ 50% of the day □ 75% of the day □ 100% of the day

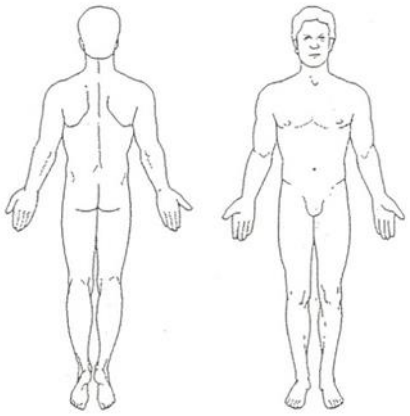
Timing of the complaint: Check appropriate box: □ Morning □ As day progresses □ Afternoon □ Evening □ While sleeping □ During activities □ After activities □ Symptoms are constant and do not change □ Other _____

Is this condition interfering with your: Circle all that apply: Sleep / Getting in or out of bed or chair / Personal care / Travel / Work/ Recreation / Lifting / Walking / Standing / Daily routine / Social activities / Exercise / Relationships / Energy level / Mood/ Other:_____

Is your complaint interfering with your daily activities? □ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

On the scale below, please circle the severity of your main complaint right now:

No Pain				***Moderate Pain***						***Worst Possible Pain***
0	***1***	***2***	***3***	***4***	***5***	***6***	***7***	***8***	***9***	***10***



←**Please Circle or make an "X" on the body diagram to the left where you have pain or other symptoms.**

What area(s) does the pain radiate, shoot, or travel to? (if applicable)? _____

_____

Area for doctor's notes:

HEALTH HISTORY

Please check **ALL** the health conditions below that apply to **you** currently or in the past.				**Family History** Mark **ALL** conditions that run in your family (Father, Mother,Sister,Brother)		Relationship:
□	Osteoarthritis/Degenerative Joint Disease	□	Whiplash Injury/Sports Injury *Date of injury:*	□	Cancer *Type:*	
□	Asthma	□	Headaches	□	Anemia	
□	Fatigue	□	Joint Pain (Circle location of pain): Shoulder, Elbow, Hip, Knee, Ankle Other:_____	□	Diabetes (check one) □Type I □ Type II	
□	Anemia	□	Migraines	□	Heart Problems / Stroke	
□	Cancer/Tumor	□	Osteoporosis /Osteopenia	□	High Blood Pressure	
□	Rheumatoid Arthritis	□	Epilepsy / Seizures	□	Genetic Disorders	
□	Depression/ Anxiety	□	Fibromyalgia / Chronic Fatigue	□	Rheumatoid Arthritis	
□	Disc Herniation	□	Genetic Disorders	□	Other (List):	
□	High Blood Pressure /Hypertension	□	Please list any other medical conditions:			
□	Heart Disease / Stroke					

Name:_____ Date: _____

WOMEN ONLY: Currently pregnant? □ Yes □ No **Painful/Abnormal Menstrual Cycle?** □ Yes □ No **Menopause?** □ Yes □ No
Miscarriage? □ Yes □ No **Do you have children?** □ Yes □ No **If "Yes" , type of birth? Circle** Vaginal or C-Section

FRACTURES (Broken Bones, Sprains, Strains, Major Trauma/Injury (List and Date:)

_____

_____

SURGERIES and/or HOSPITALIZATIONS (List and Date):

_____

_____

Have you had and X-ray, CT scan or MRI of your spine? □ Yes □ No If "Yes" Date: _____

List current prescription medications, including frequency and dosage if known. **If there are NO current medications, check here** □

Name of prescription medication	*Dosage/Start date*	4.	
1.		5.	
2.		6.	
3.		7.	

List any known allergies you have had to prescription medications. If NO medication allergies are known, check here □

1._____ 2._____

SOCIAL HISTORY

Do you exercise? □ Yes □ No **Times per week?** **Intensity?** □ Light □ Moderate □ Strenuous Type?:

Do you take nutritional supplements/vitamins? □ Yes □ No **List what you take:**

Do you drink alcohol? □ Yes □ No **Drinks per week?**

Do you drink caffeine? □ Yes □ No **How many drinks per day?** **What type?** □ Coffee □ Tea □ Soft drinks □ Energy drinks

Do you currently smoke tobacco of any kind? □ Yes □ Former smoker □ Never been a smoker
If "Yes", how often do you smoke: □ Current every day smoker □ Current sometimes smoker

Do you take OTC medication? □ Yes □ No **How often?** □ Daily □ Weekly □ Monthly □ Rarely **What type?** □ Aspirin □ Ibuprofen □ Tylenol □ Sinus/Allergy meds □ Antacids □ Other

Sleep quality: □ Poor □ Good □ Excellent Hours/night □ Back □ Side □ Belly #of pillows

Please describe your overall health right now? □ Excellent □ Very Good □ Good □ Fair □ Poor
Is your overall health: □ Improving □ Staying about the same □ Getting worse

Have you seen a Chiropractor in the past? □ Yes □ No **If "Yes": Name:** **Date:**

What are your hobbies?

INFORMED CONSENT

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment:

The primary treatment I use as a Doctor of Chiropractic is Chiropractic adjustments. The purpose of the adjustments is to restore normal function to your body by removing vertebral subluxations (areas in the spine that are not working correctly and causing interference to the nervous system) I will use that procedure to treat you. My primary technique is Activator Methods (Activator). I will utilize the Activator system to determine the locations of the subluxations, the direction of the adjustments and the efficacy of the adjustments. I will use an Activator (a mechanical instrument) on your body to make the necessary adjustments. I may also, if deemed necessary, use my hands to make the adjustments. When using the Activator instrument you will not experience any twisting, cracking or popping with the adjustment. If getting a manual adjustment you may hear an audible "pop" or "click", much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Name:_____ Date: _____

Analysis / Examination / Treatment

As part of the analysis, examination, and treatment, you are consenting to the following procedures:

- Chiropractic adjustments
- palpation
- vital signs
- range of motion testing
- orthopedic testing
- basic neurological testing
- muscle strength testing
- postural analysis
- sEMG
- Infrared Thermography
- hot/cold therapy
- radiographic studies
- Other (please explain)_____

The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation adjustments. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of adjustments. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options.

Other treatment options for your condition may include:

1-Self-administered, over-the-counter analgesics and rest 2-Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain killers 3-Hospitalization 4-Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions, degenerative arthritis and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE <u>CHECK THE APPROPRIATE "BOX" AND SIGN BELOW:</u>

☐I have read or ☐have had read to me the above explanation of the chiropractic adjustment and related treatment. I have discussed it with the Doctor of Chiropractic at Dunn Chiropractic and have had my questions answered to my satisfaction. I certify that the information I have provided is correct to the best of my knowledge. I will not hold my doctor or any staff member at Dunn Chiropractic responsible for any errors or omissions that I may have made in the completion of this form. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated:_____ Dated:_____

_____ F. Marcus Dunn, DC

Patient's Name (Please print) Doctor's Name

X_____ _____

Signature of Patient, Parent or Legal Guardian (if a minor) Doctor's Signature

Name:_____ Date: _____

FINANCIAL POLICY

SELF-PAY/INSURANCE

Patients are responsible for payment in full at the time of service. Payment options include all major credit cards, HSAs and FSAs. Dr. Dunn is out-of-network with insurances but can provide you with a receipt so that you can submit to your insurance.

MEDICARE

Or office is NOT a participating provider with the Medicare Provider Network, and we do not accept assignment from Medicare. Patients are responsible for payment at the time of service. We will, as a courtesy to you, submit claims for covered services to your Medicare carrier so that you can be reimbursed.

PERSONAL INJURY AND WORKERS' COMPENSATION

Our office policy does not allow us to accept assignment on personal injury and Workers' Compensation claims. Patients are responsible for paying at the time of service. We do not submit claims to insurance companies. If your attorney or an insurance company requires any additional information (copies of records, reports, etc.) requests must be made in writing and additional fees will apply.

MISSED APPOINTMENTS

If you are unable to keep your appointment for any reason, we ask that you give our office at least 24 hours notice so that we may make the time available to someone else who needs care. If 24 hours notice is not provided there will be no charge for the first missed appointment. The fee for second missed appointment is $25. Subsequent missed appointments will be billed at the regular fee (currently $50). Our office reserves the right to dismiss any patient who misses their appointments on a consistent basis or who fails to pay for missed appointments.

PAYMENT POLICY

Our office accepts cash, checks, all major credit cards, HSA and FSA.

EMERGENCY/AFTER HOURS CARE

Any care provided outside of normal office hours unless specifically directed by the treating doctor is considered emergency/after hours care. Just as hospitals charge higher fees for ER care, there is an additional fee for after hours care in our office. The fee is $35, in addition to the fees for the services provided.

I have read and understand the Financial Policy of Dunn Chiropractic and agree to the policies outlined herein.

_____	_____	_____
Name	**Signature**	**Date**

HIPAA/PRIVACY POLICY

We may need to use your name, phone number, email and your clinical records to contact you with appointment reminders, information about treatment alternatives or other health related information that may be of interest to you. If this contact is made by phone and you do not answer, a message will be left on your voicemail. By signing this form, you are giving us authorization to contact you with these reminders and information.

You may restrict the individuals or organizations to which your health care information is released, or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a

Name:_____ Date: _____

condition of obtaining insurance, the insurance company may have a right to health information if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to redisclosure by anyone who has access to the reminder or other information and may no longer be protected federal privacy rules.

You may have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time.

This notice is effective as of _____. This authorization will expire seven (7) years after the date on which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging I have received a copy of this authorization.

I have read your consent policy, private treatment policy, and appointment reminder policy, and agree to their terms. I am also acknowledging that I have received a copy of this notice.

_____	_____	_____
Name	**Signature**	**Date**